Vermont Health Care Innovation Project
Payment Models Work Group Meeting Minutes

Pending Work Group Approval

Date of meeting: Monday, March 16, 2015, 1:00-3:00pm, DVHA Large Conference Room, 312 Hurricane Lane, Williston

Agenda Item	Discussion	Next Steps
1. Welcome and Introductions; Approve Meeting Minutes	Kara Suter called the meeting to order at 1:04pm. A roll call attendance was taken and a quorum was present. Bard Hill moved to approve the February 2015 meeting minutes. Diane Cummings seconded. A roll-call vote was taken and the motion carried.	
2. Updates: EOC Sub-Group; VMSSP Year 3 TCOC	*Episode of Care (EOC) Sub-Group Update:* Alicia Cooper provided an update on the EOC Sub-Group, which has now met three times. Since the last meeting, the group discussed releasing an RFP for providing EOC analytics to providers; a proposal will come before this group in April, likely coupled with a funding request, for a vendor to perform these analyses. *VMSSP Year 3 Total Cost of Care (TCOC):* Cecelia Wu provided an update on Year 3 TCOC planning. Year 2 TCOC is wrapping up, and research for Year 3 TCOC has begun. Year 2 TCOC was an optional track; neither ACO opted in for the proposed categories of service (pharmacy and non-emergency medical transportation). As Medicaid starts Year 3 TCOC research, those categories will still be on the table. DVHA will also look at other services paid and adjudicated by DVHA's claims processing unit, guided by three questions: 1. Are the ACOs ready to take on the additional service in Year 3, and can the ACOs influence the delivery of the service in Year 3? 2. How is the service billed and paid for? (i.e., fee for service, year-end settlement, rebate, or other adjustment that could change the total amount paid?) 3. Have other states also included the service in their TCOC calculations? DVHA is currently researching dental, personal care services, and mental health/behavioral health/substance abuse support service, in additional to pharmacy and non-emergency transportation. Once research is	

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	concluded, DVHA will bring findings to this group for feedback (likely May or June 2015). The group discussed the following: • Is expanded TCOC still mandatory for Year 3? Yes, but DVHA hopes research will be a collaborative process. The first question DVHA asks for each category is whether ACOs are ready and able to influence delivery of the service, so this shouldn't be a one-sided mandate. Paul Harrington noted that the Year 2 experience demonstrates some reluctance from ACOs to take on an expanded TCOC, and commented that he hopes this feedback will be taken into account as Year 3 TCOC is developed. • Personal care services are quite varied – would this look at all personal care services or only some? During the research phase, DVHA is casting a wide net and looking at every service being provided. When it comes to selecting services for inclusion in TCOC, it will likely be less wide. Part of the process will be to create rational groupings for those services. • What does DVHA mean when it asks whether ACOs can influence delivery in a category? Example: Mental health services. ACOs can do something to impact care delivery in this area (example: expanding out-patient access); however, many services in this area fall under the domain of other AHS agencies, and not all are areas where ACOs can have the ability to reduce costs. One of the intents of expanding the TCOC calculation is to include a broader range of providers in this network, strengthening relationships between medical community and providers of specialized services to encourage these groups to find ways to work together in a cost-effective manner. • How will other VHCIP Work Groups be engaged? Engaging other Work Groups will come after research; collaboration on this topic is included in Year 2 VHCIP Work Group Workplans.	
3. Year 2 Vermont Medicaid Shared Savings Program (VMSSP) Gate & Ladder	Kara Suter opened a discussion of the proposed Year 2 VMSSP Gate & Ladder methodology, previously discussed at the January and February 2015 meetings of the Payment Models Work Group. The proposal has not changed since January; at the February meeting, the group decided to hold on a vote in order to provide the ACOs with additional information. The ACOs and other interested stakeholders have since been provided with additional information. Paul Harrington requested comment from the ACOs. Health*first* is not participating in VMSSP and did not have comments on the proposed methodology. OneCare was not in attendance. Joyce Gallimore from CHAC commented that CHAC is comfortable with the change. Paul Harrington moved to table a vote due to OneCare's absence. Kara Suter requested that Paul hold this motion and move onto the fourth agenda item, and noted that delay on this vote has prevented changes to contracts desired by both DVHA and the ACOs; approval by Steering Committee and Core Team will require additional time. Paul agreed to hold the motion until after the fourth agenda item, but would again make his motion if no one from OneCare had joined.	

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	Greg Robinson from OneCare joined the call during the fourth agenda item. Following the fourth agenda item, Kara reopened discussion on this item. • Greg Robinson from OneCare commented that after internal discussion, OneCare was comfortable with these changes. OneCare takes issue with the timing of the decision, which requires a decision before OneCare has had time to gather feedback from network partners and OneCare's board. OneCare requests additional time in the future to gather this feedback. Kara commented that data availability is a challenge for DVHA – claims run out takes time. Greg affirmed that OneCare was now comfortable with the changes and would vote to approve them. Diane Cummings moved to approve the new methodology. Bard Hill seconded. A roll-call vote was taken. The motion carried with three abstentions.	
4. Proposed Changes to Blueprint Payment Methodology	Kara Suter opened a discussion of comments on proposed changes to the Blueprint for Health Payment Methodology. The Work Group received three sets of comments, from Michael Bailit of Bailit Health Purchasing, Kara Suter of DVHA, and Georgia Maheras, VHCIP Project Director. Last meeting, this group suggested making recommendations to send to the Steering Committee and Core Team; the proposed changes are also being reviewed by the Blueprint governance structure. • Craig Jones commented that the Blueprint governance structure emphasizes local control; however, there has been a call for a statewide governance team with representation that mirrors local governance structures to provide guidance and make decisions about statewide standards and other issues. • Kara Suter clarified her written comments on weighting the components of the proposed payment methodology. In her comments, Kara suggested that payments gradually transition toward outcome-based payment and away from payment that rewards NCQA scoring. Kara noted that process measures are embedded in NCQA scoring, and some combination of process and outcome measures is appropriate, but suggested that the payments should be gradually weighted toward outcomes. • Paul Reiss commented that if the Blueprint is going to adopt the 2014 NCQA standards that are significantly more burdensome, payment amounts must be increased – the proposed ~$1 PMPM increase to the base payment is not sufficient to keep practices engaged and fund required quality improvement activities. Health*first* does support paying for outcomes, and wants to move toward paying for outcomes and away from paying for achieving NCQA standards. One option would be to continue paying for 2011 standards, rather than moving to 2014 standards. ○ Craig Jones noted that this is an option the Blueprint considered. The Blueprint received feedback that stakeholders wanted to continue requiring current NCQA standards. He also	**Please send comments to Mandy Ciecior (Amanda.Ciecior@state.vt.us) by March 30, 2015.** **DVHA staff will compile comments and develop recommendations for a vote at the April meeting.**

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	noted that new payments do provide a ~$1 PMPM increase, and that stakeholder feedback was that increase should be part of the base payment rather than as part of performance component. Performance payments depend on Health Service Area performance, rather than practice-based outcomes. Craig also noted that the Blueprint's recommendation to require NCQA recognition under the 2014 standards emphasizes core, must-pass elements, rather than requiring higher levels of recognition (and excessive documentation) as the Blueprint has in the past. ○ Paul Reiss noted that an increase of $1 PMPM is not a raise for practices; it costs more to achieve NCQA recognition under the 2014 standards than this increase would provide, and Medicare will no longer be participating as of 2017. He noted that BCBS and Cigna also oppose sticking with NCQA standards. ○ Ted Sirotta commented that maintaining NCQA standards do have real costs, both in terms of staff time to meet the administrative burden of achieving standards, and the time required to meet the standards, which result in decreased patient volume. ○ Kelly Lange clarified that BCBS wants to ensure the proposed methodology is reviewed from multiple angles and that weighting is considered. Will any changes need to go to GMCB? This group can provide feedback and suggestions, but Kelly believes that there are still many opinions out there and this process is in the formative feedback stage. • Kara noted that she included some questions in her comments. Will NCQA be optional? Even if so, if funding is weighted there, is it really optional? ○ Craig noted that in the current proposal, NCQA recognition remains mandatory. Blueprint leadership received comments from the ACOs and providers that recommended continuing to require NCQA recognition and to require participation in at least one community quality improvement effort. He also commented that two Newport practices recently renewed recognition based on 2014 standards and reported to Blueprint staff that the process was improved, and that NCQA had made improvements to some aspects of 2011 recognition that were excessively burdensome. Kara offered the group an opportunity to provide comments on the NCQA requirement; the group had no comments. Kara offered the group an opportunity to comment on the weighting of NCQA recognition and participation in the local collaborative, versus quality and utilization performance components. Ted Sirotta commented that he feels the weighting in the payment methodology should be more prescriptive. Kara encouraged members to share comments with staff for discussion at next month's meeting. • Utilization performance – This would likely use RUI, a composite utilization measure already used in	

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	VMSSP. Worth up to $0.75 PMPM based on HSA-level performance. • Quality performance – The ACOs are working to identify a subset of core ACO measures to recommend for this. That subset would form a composite, with benchmarks. Worth up to $0.75 PMPM based on HSA-level performance. Kara noted that DVHA staff will develop recommendations based on the current proposal, as well as recommendations for a more prescriptive proposal, to present to this group next week. Paul Harrington suggested staff also looking at relevant legislation currently before the Legislature. Paul Harrington suggested inviting Todd Moore from OneCare to present at the April meeting, since Todd has worked closely with Craig on Blueprint-ACO integration. Greg Robinson from OneCare also requested more detail on the proposed measures. Kara requested that members submit any comments to staff by 3/30. Richard Slusky asked why recommendations proposed by this workgroup would go through VHCIP governance, rather than directly to the Blueprint leadership. Georgia Maheras noted that there is overlapping jurisdiction on this issue; and a desire to gather as much feedback as possible. It would also go through AHS approval process, though Georgia is not sure whether it would need to go to GMCB. Richard suggested clarifying governance for these decisions. Craig Jones commented that statute requires a recommendation from Blueprint leadership; however, Blueprint leadership is seeking broad input to incorporate into this plan, and believes the current plan has broad stakeholder support. Kara prefers that any recommendation receives review from Steering Committee and Core Team before sending to Blueprint governance; whether or not this Work Group is sending a recommendation on for review or for a vote is up for discussion. Craig commented that having good representation from the ACOs is very important to the Blueprint.	
5. Review 2015 PMWG Workplan	Kara Suter introduced the Year 2 Workplan for the Payment Models Work Group. This revision is based on updates to the Year 2 operational plan, as well as cross-work group interactions. Kara asked members to review the Year 2 Workplan to familiarize themselves with the work ahead, and noted that staff and co-chairs would welcome comments or questions about this document. • Paul Harrington suggested that we add a presentation on the newly announced Medicare Next Generation ACO program to the group's agenda in the next few months, along with a discussion of whether Vermont's SSPs might follow that path. Kara agreed, and commented that the group will receive an in-depth presentation on this at next month's meeting. • Mike Hall commented that the workplan domains that were set out here don't capture conversations about next steps, whether that means global budgets, or the next version of ACOs, or something else. Kara agreed that this thinking is part of the Year 3 TCOC conversation, but noted that there's no one-size-fits-all payment reform solution. Mike commented that he would not want conversations about payment reform or global budgeting to focus on only on providers who are farthest along; the sooner	**Send any additional workplan comments to Sarah Kinsler (sarah.kinsler@state.vt.us).**

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	we start talking about how to include all providers across the care continuum and all populations into payment reform, the better. Mike specifically identified the value-based purchasing work described on line 26 of the workplan; Kara clarified that this refers to a specific funded project, not a broader project. • Richard Slusky noted that there is a process going on with the ACOs and payers concurrently; the overall intent is to move to value-based payments. Richard also noted that much work is now being done between the Blueprint staff, ACOs, and many community providers to coordinate care and care management activities at the local and regional level. Value-based payment incentives should support these activities and efforts toward collaboration. Exactly how payments to medical providers and DLTSS providers will be linked has yet to be determined, but is a critical issue. Richard also noted that providers' decisions to participate in VMSSP, commercial, or Medicare ACO programs, is a decision only the providers can make; the discussions will be among affected parties, though this group can provide information to inform decision-making. • Rachel Seelig commented that she would like to add input from the DLTSS Work Group to Item 10 on the Workplan (currently notes input from QPM Work Group).	
6. Public Comment, Next Steps, and Action Items	No further comments were offered. Next steps: • Finalize recommendations to be shared with Blueprint for Health leadership on payment model modifications. Please send comments or proposals to Mandy Ciecior (Amanda.Ciecior@state.vt.us) by March 30 so that a vote can be held at the April meeting. • Presentation on Medicare Next Generation ACO model, with implications for commercial and Medicaid ACO programs. • Additional comments on Workplan should go to Sarah Kinsler (sarah.kinsler@state.vt.us). • Alicia Cooper suggested a presentation from the EOC Sub-Group at the April meeting; Kara agreed. **Next Meeting:** Monday, April 20, 2015, 1:00pm-3:00pm, 4th Floor Conf Room, Pavilion Building, 109 State Street, Montpelier.	